

REPORT NO. 01-99-04

REIMBURSEMENT STUDY

LONG TERM CARE SERVICES

Medi-Cal Policy Division
Department of Health Services

*note:
Do not
replace with
earlier (superseded)
plan pages*

Rate Year 1999-2000

August 1, 1999

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DEPARTMENT OF HEALTH SERVICES REPORT

This study establishes Medi-Cal (Medicaid) reimbursement for nursing facilities, including subacute and special treatment program services, intermediate care facilities for the developmentally disabled, including habilitative and nursing services in residential type facilities, as required by Section 249 of Public Law 92-603. The methodology complies with state legislation and the requirements of the Medi-Cal program and California's State Plan.

SUMMARY OF METHODOLOGY

1. Data were collected by staff in the Department's Medi-Cal Policy Division from cost reports submitted by providers to the Office of Statewide Health Planning and Development (OSHDP) and the Department's Financial Audits Branch and were utilized to determine reimbursement by level of care, bedsize class, and geographic area, where applicable.

In conjunction with this study, the following abbreviations shall apply:

NF-A	Nursing facility - level A (also formerly intermediate care facility - ICF)
NF-B	Nursing facility - level B (also formerly skilled nursing facility- SNF)
DP/NF	Distinct part nursing facility (a nursing facility whose beds are on an acute hospital license - can be level A or B)
ICF/DD	Intermediate care facility for the developmentally disabled
ICF/DD-H	Intermediate care facility for the developmentally disabled-habilitative
ICF/DD-N	Intermediate care facility for the developmentally disabled-nursing
DP	Distinct part
DD	Developmentally disabled

2. In the few instances where nursing facility days were reported separately by level of care, but the costs were not separated, the total nursing facility days were combined.

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3. An audit adjustment, either facility-specific or by class, depending on level of care, reflecting the difference between reported and audited costs and patient days for field audited facilities, was applied to all facilities in the universe. The adjustment included the results of settled appeals.
4. When an ICF/DD-H or N provider erroneously reported calendar days instead of patient days on their cost report, the state contacted the provider and obtained the correct patient day information. This corrected information is used in the rate study.
5. Each facility's adjusted costs were updated from the midpoint of its fiscal reporting period through the midpoint of the State's Medi-Cal rate year, which is January 31, 2000, to bring all costs to a common base period. For this purpose, the reported costs were separated into the categories of (1) fixed or capital-related costs, (2) property taxes, (3) labor costs, and (4) all other costs.
6. A prospective median rate was determined for each category of reimbursement, based on projected costs for each facility. Exceptions were: (a) the state-operated facilities, which receive their actual allowable costs under the provisions of the State Plan; (b) pediatric subacute providers, whose rates are based on a model; (c) the providers of services to all DD clients, whose rates are set at the prospective 60th percentile in institutions and at the 65th percentile for providers of habilitative and nursing services in residential facilities no larger than 15 beds. Rates above the median were established for DD providers to recognize that they have a disproportionate share of Medi-Cal eligible clients.

METHODOLOGY

Data Collection

The Department receives cost reports from all long term care facilities participating in the Medi-Cal program. Data from these cost reports were used for this study. Some cost data may have been unavailable and, therefore, excluded from the study because facilities either failed to submit a timely report or received permission from OSHPD to file a late report.

Timely reports are rarely excluded from the study, although certain reports may not be useable for rate-setting purposes. Examples include: (1) reports showing no Medi-Cal days, as provided for in

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the State Plan, and (2) reports with no allocation of costs to routine cost centers. In addition, DP/NFs with Medi-Cal patient days representing less than 20 percent of the facility's total patient days were excluded from calculation of the median.

All cost reports in the universe had a fiscal reporting period ending in the State's 1997/98 Fiscal Year except for DP/NFs and subacute providers. Cost reports in the DP/NF universe had a fiscal reporting period ending between January 1, 1997 and December 31, 1997. Cost reports in the subacute universe had a fiscal reporting period ending between January 1, 1996 and December 31, 1996. There is no change from the prior year rate methodology for the fiscal period of audit reports used for the subacute program.

After checks for accuracy and completeness, the data were entered into the computer system. Each data record contained the following elements:

1. Provider number
2. Facility name and address
3. An assigned identification number (county code)
4. Licensed bedsize
5. Type of ownership (profit, nonprofit)
6. Fiscal period
7. Total patient days by level of care
8. Total Medi-Cal patient days by level of care
9. Total reported costs by level of care
10. Total plant operations
11. Plant operations by level of care
12. Fixed or capital-related costs
13. Property tax where identified
14. Facility type: freestanding or distinct part of an acute care facility.
15. For subacute providers, patient days for ventilator and non-ventilator patients

If a DP/NF did not file a cost report to be used in the study and/or no audit data for that time period was available, the data used to establish the prior year's projected cost was used to determine the facility's reimbursement rate.

Audit Adjustments

Field audits were performed in accordance with regulations published in Title XVIII of the Social Security Act (Medicare), Title 22 of the California Code of Regulations (CCR), and the California State Plan. The primary audit guidelines came from the Federal Department of Health and Human Services Manual (HCFA-15).

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The adjustments, which are based on the findings of field audits, account for the difference between audited and reported costs and patient days. The 1999-2000 rate computations used field audit findings based on reports with fiscal periods ending between July 1, 1997 and June 30, 1998 except for DP/NFs which used reports ending in calendar year 1997.

In accordance with the field audit requirements, the NF-Bs in each of the 1-59 and the 60+ bedsize groups were randomly selected in order to develop the audit adjustments. The sample sizes were large enough to produce audit ratios with a 90 percent confidence that did not deviate by more than 2 percent from the estimated class population. The adjustments were calculated as the ratio of audited to reported costs and patient days. In the case of class audit adjustments, audited costs were modified by a factor reflecting share-of-cost overpayments. The results of settled appeals of audits from prior rate studies were applied to obtain final ratios. The class audit adjustments were:

<u>Bedsizes</u>	<u>Ratio</u>
NF-B 1-59	.92764
NF-B 60 +	.93649
ICF/DD-H	.89205
ICF/DD-N 4-6	.87652

NF-A Adjustment

The entire universe of NF-As was audited because the small number of facilities was insufficient to create a reliable sample. Facility specific audited costs are used if the fiscal period end of the audit report corresponds with the audit period used in the rate study. A facility-specific audit adjustment was applied to those facilities whose audit report did not correspond. If, for any reason, a field audit was not performed, the average audit adjustment of the peer group was applied.

In the few instances where NF-A and NF-B days were reported separately, but the costs were not, the NF-A and NF-B days were combined.

DP/NF-B and Subacute Adjustment

Actual audited costs were used when the fiscal period of the audit agreed with the fiscal period of the cost report used in the rate study. The NF-B 60+ adjustment was applied to facilities whose audit reports were not final by July 1, 1998.

ICF/DD Adjustment

The entire universe of ICF/DDs was audited because the small number of facilities was insufficient to create a reliable sample. Facility specific audited costs are used if the fiscal period end of the

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audit report corresponds with the audit period used in the rate study. A facility specific audit adjustment was applied to those facilities whose audit report did not correspond. If, for any reason, a field audit was not performed, the average audit adjustment of the peer group was applied.

ICF/DD-H & ICF/DD-N Audit Adjustment

A sample of ICF/DD-H facilities was audited, and the bedsizes were combined to develop a composite adjustment. A sample of ICF/DD-Ns, 4-6 bedsize class, was audited to develop an audit adjustment. For the ICF/DD-N, 7-15 bedsize class, a facility-specific adjustment was applied to each facility that was audited and the average audit adjustment of the peer group was applied to unaudited facilities.

Cost-of-Living Update

Adjusted costs for each facility were updated from the midpoint of the facility's report period through the midpoint of the State's Medi-Cal rate year, which is January 31, 2000.

Adjusted costs were divided into categories and treated as follows:

1. Fixed or Capital-Related Costs - These costs represent depreciation, leases and rentals, interest, leasehold improvements, and other amortization. No update was applied.
2. Property Taxes - These costs, where identified, were updated at a rate of 2 percent annually, converted to .1652 percent per month. Some facilities did not report property taxes, either because they were nonprofit and exempt from such tax, or because they had a lease or rental agreement that included those costs.
3. Labor Costs - A ratio of salary, wage, and benefits (SWB) costs to the total costs of each facility was used to determine the amount of the labor cost component to be updated. The ratio was determined by using the overall ratio of salaries and wages to total costs from data extracted by OSHPD from the labor report, and adding costs that represent all wage-related benefits, including vacation and sick leave.

The final SWB ratios were: .6233 for NF-Bs, .5494 for NF-As, and .6322 for ICF/DDs. The labor costs for ICF/DD-Hs and ICF/DD-Ns are facility-specific, obtained directly from each cost report in the study. For DP/NFs and subacute providers, a ratio of SWB cost, as described above, to the total cost less fixed and capital related costs was used to determine the amount of labor cost component to be updated. The ratio was .6233. Labor costs for each facility were updated from the midpoint of its cost reporting period to the midpoint of

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the State's rate year (January 31, 2000). The update tables used industry-specific wage data reported by the facilities as described in the attached Report No. 01-99-01.

4. All Other Costs - These costs are the total costs less fixed or capital-related costs, property taxes, and labor costs. The update for this category utilized the California Consumer Price Index (CCPI) for "All-Urban Consumers" and figures projected by the State Department of Finance through January 31, 2000.

Subacute Services

The subacute rate methodology differs slightly from the regular NF-B and DP/NF-B rate methodology. The differences are that projected costs were developed for ventilator and non-ventilator patients and that additional ancillary costs are included in the cost projections.

The projected cost that was developed for each subacute provider contained the combined costs for ventilator and non-ventilator patients. Subacute providers did not maintain adequate financial records to differentiate the cost difference between ventilator and non-ventilator patient care. The ventilator and non-ventilator costs for each provider were assumed to be the same except for the cost of the ventilator equipment. The provider's total ventilator equipment cost was determined by multiplying the projected ventilator equipment cost by the total ventilator days. This amount was deducted from the total projected cost of the subacute provider to determine the cost of the subacute unit, excluding ventilator equipment cost. The non-ventilator cost was divided by the total patient days to determine the non-ventilator projected cost. The projected ventilator cost was calculated by adding the cost of the ventilator equipment to the non-ventilator projected cost. The data used for ventilator/non-ventilator days were obtained from the following sources in this order; 1) total patient days from the audit reports; 2) Medi-Cal patient days from the audit reports, or 3) Medi-Cal paid claims data for the calendar year of the audit reports used in the rate study. If the data were obtained from 2 or 3, the ratio of ventilator days to non-ventilator days was applied to the total patient days to approximate ventilator and non-ventilator days for the cost report period.

The subacute rate includes additional ancillary costs. Where available, the facility's projected cost was based on the audited ancillary cost data. In the event that audited ancillary costs were not available, the facility's projected cost was based on the median of the projected subacute ancillary costs of the facilities in the study that had audited ancillary costs.

Pediatric Subacute Services

The model for pediatric subacute provides for therapy evaluations and allows for reimbursement of rehabilitation therapy and ventilator weaning services for qualified patients and some rehabilitation

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therapy services for patients who do not qualify for this supplement. The model approach continues because of the lack of sufficient reliable pediatric subacute cost data. The detailed description of the model methodology is in a report on file with the State agency.

Adjustment for Changes in Licensure Fees

The updated cost of each facility reflected changes in licensure fees which are modified every July and billed to providers by the Department's Licensing and Certification Division.

Workplace Violence

An amount was added to the Medi-Cal rates for training cost associated with guidelines adopted by the California Department of Industrial Relations, Division of Occupational Safety and Health that dealt with violence in the workplace. This add-on continues to ripple out for DPs and subacute facilities using older cost report data.

Minimum Wage Add-on

An amount was added to facilities' projected costs to compensate for the combined effect of the October 1, 1996 federal and March 1, 1997 State minimum wage increases.

In addition, an amount was added to facilities' projected costs to compensate for the combined impact of the second component of the federal minimum wage increase which was effective September 1, 1997, and the State minimum wage increase which was effective March 1, 1998. A component was also built into the rates to cover the indirect costs of avoiding wage compaction resulting from the minimum wage increases. These add-ons continue until the costs are fully reflected in cost reports used for the rate study.

Minimum Data Set

Reimbursement rates for skilled nursing facilities (NF-Bs), subacute facilities, and intermediate care facilities (NF-As) contain a component to cover the costs of implementing the Minimum Data Set, which requires all of these facilities to electronically transmit certain long term care data items to the State.

Life Quality Assessments

An amount was added to rates to reimburse staff costs for assessing and quarterly monitoring of

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clients in ICF/DD, ICF/DD-H and ICF/DD-N facilities to determine the life quality offered to such clients.

Criminal Background Checks

The add-on covers costs of rolling and processing fingerprint cards for background checks on direct care staff in ICF/DD and ICF/DD-N facilities retroactive to April 1, 1999 effective date.

Bloodborne Pathogen

Add-on reimburses facilities for a State mandate requiring monitoring and reporting of needlestick injuries and conversion by the industry to new safer needle technology to avoid spread of bloodborne pathogens.

Drug Disposal

The add-on reimburses added costs of required transportation and incineration of outdated or leftover drugs and medications."

Wage Pass-Through

The add-on provides for freestanding NFs, DP/NFs, subacute facilities and transitional care providers to pass through to direct care staff (ie registered nurses, licensed vocational nurses and nurse assistants) a wage increase. This wage pass-through does not apply to transitional inpatient services which are provided by acute care hospitals in their acute beds.

Determination of Reimbursement Peer Classes

NF-A and NF-B classes were peer grouped by bedsize, level of care, and three geographical locations: (1) Los Angeles; (2) the six Bay Area counties (Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara); and (3) all other counties. The DP/NF-B class was determined on a statewide basis by level of care, with no bedsize nor geographical grouping.

Classes for ICF/DDs were established on a statewide basis, by bedsize and level of care only, because there was an insufficient number of facilities for geographical grouping. The ICF/DD-H and ICF/DD-N classes were determined on a statewide basis by bedsize only.

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